HCBS Asked & Answered

DD Waiver Providers - October 31, 2022

HOME AND COMMUNITY-BASED SERVICES
WYOMING MEDICAID DIVISION OF HEALTHCARE FINANCING

Why does CareBridge Electronic Visit Verification (EVV) limit where and how services can be provided? Specifically, logging in without service is hard and gives the impression that services should be provided in the home.

A: EVV is not intended to hinder or interrupt service provision in any setting. The purpose of EVV, as required by the 21st Century Cures Act, is to confirm that services with personal care elements are delivered in authorized locations, document the caregiver delivering the service, and to capture when the service was delivered. The punch times are in alignment with Wyoming Medicaid Rule Chapter 45, Section 8 for DD providers, which does not allow for the rounding up of units. In order to receive payment for a 15-minute unit, a full 15 minutes of service must be provided.

Providers who utilize the app on their smartphones or tablets are able to log in and out without service; those punches will be updated when service is available. This is known as an offline visit. To conduct offline visits, the participant must be designated as a favorite in the app, which is indicated by a gray star. Offline visits are not available if the participant is not designated as a favorite in the app.

For more information on offline visits, please visit the Provider Organization Training within the CareBridge resource library.

How does the billing work for daily respite units and CareBridge EVV when two (12am - 12:59p, 1pm-11:59pm) or more staff provide the service?

A: Due to a recent system update, the EVV system does not require providers to clock-in/clock-out at midnight. The visit will appear to span across midnight in the provider portal, but the back-end billing will break the visit according to date of service to accurately bill daily respite units. However, visits are not allowed to span more than two days. Providers will need to clock out and then clock back into the service to avoid this challenge. Many providers may already have this issue resolved. If you are having specific challenges with services that bridge midnight, please contact CareBridge by email wyevv@carebridgehealth.com or CareBridge Customer Support (855) 912-3301.

Additionally, the Division is aware that respite visits are not correctly calculating daily units and some providers have experienced unit overutilization. Providers who have been paid for more than one daily unit of respite in a single date of service should have recently seen payment adjustments on their remittance advice, and the visits corrected in the system. Additional system fixes to correct billing errors for daily respite units are planned to be implemented no later than the end of November 2022. The Division will provide notification as the system fixes are implemented.

Are there any limitations to manual entries for EVV in the CareBridge portal?
A: Currently, manual entries for EVV are not limited. However, compliance standards for manual entries will be in effect and communicated to providers, case managers, participants, and family members as they are implemented.

How do we do a log in with CareBridge if the participant is out of state on a trip?
A: The participant's primary address is sent to the CareBridge EVV system via Electronic Medicaid Waiver System (EMWS) data. If services are provided in another location, it is encouraged that a secondary address be added to the participant's locations within the CareBridge portal. Secondary addresses can be added any time before a visit takes place. Secondary addresses won't be permanently added to any other systems, such as EMWS.

What documentation are providers required to give to case managers, as it pertains to EVV?
A: Providers are required to provide case managers with all service documentation. This includes, but is not limited to, EVV unit and scheduling reports, service provision documentation and schedules, all incident reports, and medication assistance records (MARs). Documentation must meet the standards outlined in Wyoming Medicaid Rule Chapter 45, Section 8. CareBridge EVV alone does not meet documentation standards for service delivery as it does not include detailed description of the services provided.

Can claims information be obtained for CareBridge EVV service, or is the CareBridge documentation the claims information?
A: CareBridge does submit claims data to the Benefits Management System (BMS) on behalf of the provider. The provider can view the majority of claims information on the Claims tab within the CareBridge system. However, providers are able to review more detailed claims data by logging into the Medicaid Provider Portal at https://www.wyomingmedicaid.com

How accurate is the Units Used data that appears in EVV? How long is the catch up time for the units?
A: The Scheduled Units and Billed Units shown as graphics on the authorization detail pages should be accurate in real-time. The provider can also view the hours equivalent by clicking the toggle button next to 'Units'. The Scheduled units graphic includes future scheduled appointment units as well as used units from completed visits that have not yet been billed. The Billed units graphic is only showing units that have been exported for billing and are not in a terminal status of Paid/Denied. A provider can get a more detailed breakdown of units lower down on the Authorization Details page by selecting

the drop-down button next to Authorization Segments. The Units Paid calculation will not be in real-time since that data is provided by BMS. The Division and CareBridge are aware that respite daily units are still a concern and are working to resolve the issues.

Is there any difference between the background screening process for participant-directed employees and the background screening process for traditionally certified providers?
A: The elements of the background screening, which can be found in Wyoming Medicaid Rule, Chapter 45, Section 14, are the same regardless of whether or not the services are delivered traditionally or through participant-direction. However, background screenings for participant-directed employees are processed by ACES$ and background screenings for traditional providers and their staff members are processed by the Wyoming Department of Health (WDH). ACES$ partners with WDH to obtain some components of the background screening. It is the Employer of Record's (EOR's) responsibility to ensure that their employees work with ACES$ to complete the required background screening.

Who do I need to contact about the status or results of a background screening?
A: The Division recommends contacting the processing entity for the status of your background screening.

If the background screening in question is for a participant-directed employee, work with ACES$.

The WDH Director's Office is the processing entity for the background screenings for traditional providers. The Background Specialist can be contacted directly at wdh.backgroundchecks@wyo.gov or (307) 777-7276. The Credentialing or Incident Management Team may also be of assistance. Please contact them as needed.

What is the new Central Registry process? Who can I contact with questions or concerns about the Central Registry?
A: Central Registry screenings are performed by the Department of Family Services. This is required and completed as part of the WDH background screening process. DD providers should be submitting their information through the WDH Background Specialist to complete the Central Registry screening. The Background Specialist logs all documents received, the results of the screening, and creates the "Meets" or "Does not Meet" letter based on those results.

For participant-directed employers of record (EORs) or employees with questions about the Central Registry process or their results, please contact ACES$.

Are providers able to have staff begin working with participants once their background screening has been submitted, but prior to receiving the result of their screening?
A: Yes. Wyoming Medicaid Rule, Chapter 45, Section 14 (f) allows, at the discretion of the provider or employer of record, an individual staff member to provide unsupervised services on a provisional basis to a participant who is eighteen (18) years or older following the submission of the background screening, as long as disqualifying crimes or relevant criminal records are not disclosed on the application, until the individual staff member is cleared through successful background screenings.

While waiting for background results, what specifically could a staff not do?
A: Wyoming Medicaid Rule Chapter 45, Section 14(h) states that staff shall not provide any services to participants ages seventeen (17) or younger until all background screening components are completed and results meet the requirements of a successful background screening.

What can providers expect for the COVID-19 flexibilities when the public health emergency (PHE) is declared over? What is the process for a flexibility to become waiver rule?
A: The unwinding of the PHE will be a deliberate process that will assist participants, families, providers, and case managers to transition back to pre-PHE waiver standards. The HCBS Section will ensure that communications about the PHE are prompt and clear; discussions are ongoing at the federal level regarding the period of time states will have to come into compliance with their COVID-19 flexibilities. At this point, the HCBS Section has 6 months following the expiration of the PHE, as approved in various Appendix K submissions. However, if that time period changes, the HCBS Section will communicate that change.

In the meantime, please use the Suggestion Box on the HCBS Website to recommend specific flexibilities that you believe will be beneficial to remain in place after the PHE. HCBS staff will review these suggestions for future consideration.

Is the Medicaid still waiving the requirement for the yearly Medicaid renewal packets to be completed by and mailed from families?
A: Yes, as part of the PHE, Medicaid renewals for participants and families are on hold. When the PHE ends, Wyoming Medicaid will provide guidance and deadlines for application submissions.

Are Continuing Education Units (CEUs) still required for Individual Habilitation providers?
A: Yes, eight (8) hours of continuing education are required of providers of Individual Habilitation per Wyoming Medicaid Rule, Chapter 45, Section 5 (b)(vii).

If a waiver participant is out of town for longer than 90 days, and receives case management services by phone while out of town, will the participant maintain eligibility for the waiver?
A: This question cannot be answered with one blanket response due to the complexity of the issue, including potential impact on Medicaid eligibility, the appropriate delivery of case management services, and other concerns. Please contact your BES regarding specific questions about the length of time a participant can be out of town while on the waiver.

Who can I call when I have questions? Emailing is not always helpful.
A: Due to the workloads of HCBS Section staff, providers are no longer assigned to a single staff member. Please direct your questions to the appropriate team, and please feel free to request a phone call at a time that is convenient to your schedule. An email request for a phone call is not a problem.

If you have questions about your certification, renewal, or updating your information please contact the credentialing team at wdh-hcbs-credentialing@wyo.gov. If you have questions, concerns, or complaints you can also contact the Incident Management Specialist assigned to your area.

If a participant lives in their own residence or with family and receives services in their residence, do participant/family owned cameras need to be included in a plan of care as a restriction?
A: Cameras installed in a private residence are outside of the authority of the HCBS Section. However, Wyoming Medicaid Rule, Chapter 45, Section 13(b)(iv) states that any waiver provider must ensure services are delivered in a way that ensures the individual's rights, including those of privacy and dignity. In particular, cameras monitoring bedrooms and bathrooms must be turned off during the provision of waiver services. If the provider has concerns about participant privacy or dignity, they should address those with the plan of care team.

Who should teams reach out to for concerns regarding team functioning? What training is available for participants and legally authorized representatives (LARs)?

A: Participants and LARs have the right to be informed and should be involved in the planning and implementation of the person centered service plan. If a participant or LAR has concerns about team functioning, they should work with their case manager. If this issue persists, formal complaints can be filed on the homepage of the HCBS website or through the Wyoming Health Provider (WHP) Portal. Case managers are responsible for facilitating team function. If the problem is with the case manager, please file a complaint

At any point, the LAR or participant has the right to choose a new case manager or provider if the team is not functioning to their satisfaction. The Division offers a searchable, public listing of Wyoming case managers and providers on the home page of the HCBS website.

The HCBS website is full of information that is available for participants and LARs anytime. All provider and case manager training are on the HCBS website in a variety of formats for access and review by participants and LARs.

Should participants and their families be receiving monthly documentation for verification purposes and to address concerns immediately?

A: Case managers are responsible for documentation review as a part of the case management service definition and requirements. The case manager is also responsible for spending time with the participant and the LAR (if applicable) to discuss any service concerns.

Case manager monthly reports (CMMRs) are meant to be completed in consultation with the participant and the LAR (if applicable). The case manager is not required to get approval from the participant or LAR before submitting their documentation, however documentation is part of the participant's file and should be available to the participant upon their request. If the case manager is not addressing service delivery concerns during conversations with the participant and LAR, please request that the case manager address these concerns. If necessary, file a complaint on the HCBS Section website.

Would the Division consider offering monthly support calls and training for participants, guardians, and LARs?
A: The HCBS Section is responsible to the Centers for Medicare and Medicaid Services (CMS) for ensuring that providers and case managers have the information they need to deliver services appropriately, which is the intent of these training sessions. However, training, support, and resources for participants and LARs is something the Section will consider moving forward.

Who can assist with locating and funding Durable Medical Equipment (DME)?
A: Information regarding DME can be found in the DME manual https://wymedicaid.telligen.com/wp-content/uploads/2022/07/WY-DME-Manual_TelligenV1_rev1_09.28.22.pdf

This link is also available on the DD Providers and Case Managers page within the *Case Manager References* toggle.

Some DME is covered by the Wyoming Medicaid State plan, but additional resources may be available through the waiver. Participants in need of DME should work with their case managers to determine the best funding source.

How do providers find out if someone has been decertified in the new hiring requirements?
A: At this time the Division does not have a mechanism for providers to verify staff against previously decertified providers. However, the Division is working to establish a public mechanism and will provide information about access and use once it is available.